

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 0 — 0 3 4

2. STATE:

Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

July 1, 2000

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.304; 440.130

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ 217.55b. FFY 2001 \$ 879.35

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 13d, Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

SAME (TN 00-06) Pending

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to restore the seven percent (7%)  
reduction previously made in the reimbursement rates in the Mental Health Rehabilitation Program  
for high need services for children and adults and for medium need services for children.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED: The Governor does  
not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

David W. Hood

14. TITLE:

Secretary

15. DATE SUBMITTED:

September 25, 2000

16. RETURN TO:

State of Louisiana  
Department of Health and Hospitals  
1201 Capitol Access Road  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

09-27-00

18. DATE APPROVED:

8 MAY 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1 JULY 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

Calvin G. Cline

21. TYPED NAME:

CALVIN G. CLINE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR  
DIV OF MEDICAID & STATE OPERATIONS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B  
ITEM 13.d. Page 3

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION      Medical and Remedial  
42 CFR          Care and Services  
447.304        Item 13.d.(cont'd.)  
440.130

2. Reimbursement for services specified in the 90 day action strategy plan in the approved MHR Service Agreement shall be paid at a flat monthly rate for the appropriate frequency schedule (High, Medium, or Low Need Services for Children/Youth and Adults), which is determined by medical necessity.

Flat monthly rates are based on estimated number of hours of each service in each frequency schedule (weighted by usage determined by a study of prior history for similar services) and hourly cost of composite services, including all provider costs regardless of location in which services are provided (based on historical reimbursement for those services).

Rates for each frequency schedule are based on 66.6% of the estimated cost of services for the appropriate frequency schedule.

Payment is contingent upon the delivery of 80% of the services contained in the Service Agreement. Reimbursement for the first month will be made after 80% of one-third of the total services have been provided. Reimbursement for the second month will be made after 80% of two-thirds of the total services have been provided. Reimbursement for the third month will be made after 80% of total services have been provided.

STATE <u>Louisiana</u>	A
DATE REC'D <u>09-27-00</u>	
DATE APPV'D <u>05-08-01</u>	
DATE EFF <u>07-01-00</u>	
HCFA 179 <u>LA-00-34</u>	

TN# LA-00-34 Approval Date 05-08-01 Effective Date 07-01-00

Supersedes

TN# LA-00-06